



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

RELIANT REHAB ABILENE

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-1008-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

DECEMBER 2, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please consider this is an appeal regarding the initial decision for the total amount billed \$13,550.50."

Amount in Dispute: \$13,555.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual inadvertently paid \$4,815.30, which is incorrect per its methodology. For this reason Texas Mutual will issue an additional payment of \$3,292.41."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2013 through March 12, 2013	Inpatient Rehabilitation Hospital Services	\$13,555.50	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404, effective March 1, 2008, provides for the reimbursement guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code).
 - 895-133.210 requires itemized statement for hospital services.

- CAC217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217-The value of this procedure is included in the value of another procedure performed on this date.
- 426-Reimbursed to fair and reasonable.
- CAC193-Original payment decision is being maintained. Upon review it was determined that his claim was processed properly.
- 891-No additional payment after reconsideration.
- CAC18-Duplicate claim/service.
- 878-Appeal (Request for Reconsideration) previously processed. Refer to rule 133.250(H).

Findings

1. 28 Texas Administrative Code §134.404(a) states “Applicability of this section is as follows. (1)This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.”
28 Texas Administrative Code §134.404(b)(1) states “‘Acute care hospital’ means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.”
The requestor provided inpatient rehabilitation services; therefore, 28 Texas Administrative Code §134.404 is not applicable to the disputed services.
2. 28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection 134.1(f), which states that “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.” Review of the submitted documentation finds that:
 - The requestor’s position statement asserts that fair and reasonable reimbursement would be 100% of total billed charges.
 - The requestor did not support position that reimbursement of \$13,555.50 would be a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	12/04/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.